CARLSMITH BALL LLP

DAVID LEDGER (CNMI BAR NO. F0195)
Carlsmith Ball LLP Building
Capitol Hill
Post Office Box 5241
Saipan, MP 96950-5241
Tel No. 670.322.3455

Attorneys for Defendant
Aviation Services (CNMI), Ltd. dba Freedom Air

UNITED STATES DISTRICT COURT

FOR THE

NORTHERN MARIANA ISLANDS

MOSES T. FEJERAN and QIANYAN S. FEJERAN, Plaintiffs, vs. AVIATION SERVICES (CNMI), LTD. dba FREEDOM AIR, Defendant.	CIVIL ACTION NO. 05-0033 **SUBPOENA DUCES TECUM; CERTIFICATE OF SERVICE**

TO: MR IMAGING GROUP
Custodian of Records
384 Duenas Drive
Tamuning, Guam 96911

Your deposition will be taken at the law offices of Carlsmith Ball LLP, Suite 401, Bank of Hawaii Building, 134 West Soledad Avenue, Hagåtña, Guam 96910 on **Monday, August 28, 2006 at 10:00 o'clock a.m.** on behalf of Defendants in the above-entitled action. Please bring the following items with you:

1. MR images regarding Moses Fejeran, Social Security #586-64-4606, Date of birth July 30, 1940.

2. Any other diagnostic films such as x-rays, fluoroscope, or like media, regarding Moses Fejeran.

DATED: Hagåtña, Guam, August 18, 2006.

CARLSMITH BALL LLP

DAVID LEDGER
Attorneys for Defendant
Aviation Services (CNMI), Ltd.
dba Freedom Air

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on the 21st day of August 2006, I will cause to be served, via hand delivery, a true and correct copy of **SUBPOENA DUCES TECUM** to the following Counsel of record.

George L. Hasselback, Esq.
O'Connor Berman Dotts & Banes
Second Floor, Nauru Building
Post Office Box 501969
Saipan, MP 96950

DATED: August 18, 2006.

DAVID LEDGER

Authorization for Release of Medical Records and Related Information

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Patient name: **Fejeran, Moses T, DOB 7-30-40** ID Number: **CHC # 10-33-19**

Persons/organizations authorized to provide the information: **MR IMAGING GROUP**

Persons/organizations authorized to receive the information: **Carlsmith Ball LLP, Attorneys, and David P. Ledger, Attorney.**

Specific description of information to be used or disclosed (including date(s)): **Regarding only treatment rendered to treat the right leg, and inparticular the right knee, and/or ankle and/or hip, all medical records, including x-ray films, fluoroscope films, and MRI imaging of the right knee.**

Specific purpose of the disclosure: **Assessment of the injury by other physicians**.

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

No __X__ Yes (describe) _____

This authorization will expire: **Upon disclosure of the medical records identified above.**

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurance from the above-named persons/organizations

authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

III. Signature of Patient or Patient's Representative

M Tijeras 8/4/06

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

Printed name of the patient's personal representative: _____

Relationship to the patient, including authority for status as representative: _____